HEALTH REIMBURSEMENT ACCOUNT
REIMBURSEMENT CLAIM FORM

Varipro
BENEFIT ADMINISTRATORS

Employee Instructions:

Reimbursement form must be complete and clear. **Failure to answer any questions or provide proper documentation may delay payment.**

1. Attached **ALL** pages of your Explanation of Benefits (EOB).
2. Balance due bills from your doctor or other service providers **will not be accepted.**

Participant Information

Employer: ____________________

Employee Name: ____________________ **Date of Birth:** ____/____/____

Street Address: ____________________ ☐ **Check if new address**

City: ____________ **State:** ________ **Zip Code:** ________

Email Address: ____________________ ☐ **Check if new email address**

To the best of my knowledge and belief, this Health Reimbursement Claim form is complete and true. I certify that the member has received the services described below on the date of service indicated and that the expenses qualify as a valid medical service under my Employer Benefit Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent/spouse in the Plan. I certify that I have not been reimbursed previously for these expenses under any other Flexible Spending Account or Benefit Plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit. ACCEPTANCE OF FACSIMILE OR SCANNED SIGNATURES: Document signatures delivered by facsimile or email/pdf are valid and enforceable. Such facsimile or scanned signatures shall have the same force and effect as an original signature.

Participant Signature *(Required)* ____________________ **Date:** ____________

Name of Person Receiving Service	Relationship to Employee	Type of Service (Only eligible services will be reimbursed)	Reimbursement Requested
		☐ Deductible ☐ Copay ☐ Coinsurance ☐ Prescriptions ☐ Dental ☐ Vision/Hearing ☐ Other: ______	$
		☐ Deductible ☐ Copay ☐ Coinsurance ☐ Prescriptions ☐ Dental ☐ Vision/Hearing ☐ Other: ______	$
		☐ Deductible ☐ Copay ☐ Coinsurance ☐ Prescriptions ☐ Dental ☐ Vision/Hearing ☐ Other: ______	$
		☐ Deductible ☐ Copay ☐ Coinsurance ☐ Prescriptions ☐ Dental ☐ Vision/Hearing ☐ Other: ______	$
		Total Reimbursement Requested to be paid:	$

Please refer to your benefit plan for your specific plan reimbursement schedule.

How to Submit Claims

Electronically Upload claims online:	By FAX:	By Mail:
www.member.varipro.com **Email:** hra@varipro.com	**FAX Number:** 844-902-4564 **Number of Pages:** ________	Varipro 5300 Patterson Ave SE, Suite 150 Grand Rapids, MI 49512

Customer Service: 800-732-3412